Minutes of the meeting of the Audit and Compliance Committee of the Board of Directors of the Cook County Health and Hospitals System held Wednesday, April 10, 2013 at the hour of 10:00 A.M., at 1900 West Polk Street, in the Second Floor Conference Room, Chicago, Illinois.

I. Attendance/Call to Order

Chairman Muñoz called the meeting to order. In the absence of a quorum at that time, he appointed Director Michael as a substitute Member of the Committee for quorum purposes; therefore, a quorum of members was present.

Present: Chairman Luis Muñoz, MD, MPH and Director Edward L. Michael (substitute Committee Member) (2)

Director Hon. Jerry Butler and Gerald Bauman (non-Director Member)

Absent: Directors Reverend Calvin S. Morris, PhD and Dorene P. Wiese, EdD (2)

Additional attendees and/or presenters were:

Cathy Bodnar – System Chief Compliance and Privacy Officer
John Cookinham – System Chief Financial Officer
Marie Franklin – McKesson Revenue Management Solutions
Tim Heinrich – McGladrey LLP
Randolph Johnston – System Associate General Counsel
Pat Kitchen – McGladrey LLP
Natasha Lafayette-Jones – Director of Health Information Management
Ram Raju, MD, MBA, FACS, FACHE – Chief Executive Officer
Elizabeth Reidy – System General Counsel
Deborah Santana – Secretary to the Board
Thomas Schroeder – System Director of Internal Audit
John Jay Shannon, MD – Chief of Clinical Integration

II. Public Speakers

Chairman Muñoz asked the Secretary to call upon the registered speakers.

The Secretary called upon the following registered speaker:

1. George Blakemore Concerned Citizen

III. **Report from System Corporate Compliance Officer (Attachment #1)

A. Activity Report
B. Update - quarterly coding statistics
C. Kickoff – Accounting of Disclosures Survey

Cathy Bodnar, System Corporate Compliance and Privacy Officer, presented her report containing the following: quarterly statistics on reactive compliance issues; annual sanction report for employees and vendors; and CY12 breach statistics. Information was also provided regarding the following: Board education on the final HITECH Omnibus Rule; quarterly monitoring statistics for facility/technical coding and professional fee coding; and kick-off of the Accounting of Disclosures Survey. The Committee reviewed and discussed the information.

III. **Report from System Corporate Compliance Officer (continued)

During the discussion of the information regarding coding, Director Michael referenced page 15 of the report; he inquired further regarding the action under which a coder is removed from production. Marie Franklin, Coding Manager for McKesson Revenue Management Solutions, responded that when a coder scores in the red zone, the coder is removed from production, and the errors are reviewed by Compliance and Education. The coder is given thirty additional charts to review; if the coder passes at 90%, the coder is put back into production, and under a quality assurance process, 25% of their charts have to be reviewed. If a coder fails the remedial batch, the coder is still out of production; another batch is given. Depending on the errors, if it is the same error, then management would move toward corrective action. If it is a different error, management would provide the education and request additional charts to review. Director Michael inquired as to the approximate percentage of coders that are out of production and being retrained in a given quarter. Ms. Franklin responded that, overall, perhaps less than 10% are removed from production.

Natasha Lafayette-Jones, Director of Health Information Management (HIM), provided additional information regarding the update on coding. She reviewed some of the internal processes for coding; she noted that previously some results were submitted that were their first external audit results. She indicated that, with regard to inpatient results, coding accuracy is at 94.1%; the System's benchmark for coding standard is 95%. Management takes the external results and works with the coders to educate; the entire group gets the education on what happened, how it happened and how to avoid it. She stated that audit results on coding for the Emergency Rooms (ERs) are expected in May and will be brought to this Committee and to the Board[1].

For the ER audit, she stated that they will segregate out the internal staff and results and the external vendors' results; in the case of ER, facility and professional coding will be reviewed from an external perspective.

Director Velasquez inquired as to the total number of coders on staff at the System, and whether they are all certified. Ms. Lafayette-Jones responded that twenty-three coding positions are budgeted for the System; twelve positions are filled and eleven are vacant. There are ongoing efforts to recruit and ensure that the System reaches the proper staffing model. With regard to junior coders, which are non-certified coders, Ms. Lafayette-Jones stated that there are two budgeted positions, both of which are filled. She referenced a previous letter of agreement, under which the System had offered education to ramp-up the coders; she stated that the junior coders are the two coders that were not able to achieve the level prescribed. Under the agreement, the junior coders perform certain types of coding that are not as impactful as more complicated or higher-acuity cases.

Ms. Lafayette-Jones stated that there are efforts to centralize coding. In conjunction with the ICD-10 project manager, she stated that there is a need to centralize coding to ensure that the System can properly educate its coders.

The current staffing model addresses mainly the acute care coding, which includes inpatient, ERs, same-day surgery and observation accounts. This staffing model does not accommodate outpatient, which is predominately what McKesson does from a professional fee perspective. Chairman Muñoz clarified that the additional work load that exists that is not addressed by the current staffing levels is addressed by the System bringing on external coding vendors to bring the System to the levels that are needed. Ms. Lafayette-Jones responded affirmatively. Chairman Muñoz inquired further regarding acute care coding and coding for services that fall outside that category. Ms. Lafayette-Jones stated that, with regard to ambulatory services and clinics, staff from HIM and Medical Records will also code some of the minor procedure areas, where doctors are doing invasive and not basic procedures.

III. **Report from System Corporate Compliance Officer (continued)

The Committee held an extensive discussion regarding coding for Trauma services. John Cookinham, System Chief Financial Officer, stated that an issue arose in which the System received notice from the State that the System had virtually no Trauma activity, which is not the case. This issue appears to be tied to revenue codes, rather than to medical coding; it was determined that the Charge Description Master (CDM) and the revenue code setup for the services in that area were not set up properly.

Following the discussion of the matter, Chairman Muñoz stated that a report on the issue would be useful, to review and get a sense of how the issue evolved and the magnitude – in order to understand whether it was an issue involving, for example, information flow, process, or information technology. Mr. Cookinham responded affirmatively; he stated that an assessment of the issue will be brought back to the Committee[2].

During the review of the information on the Accounting of Disclosures Survey, Ms. Bodnar noted that efforts are currently underway to include language in the Conflict of Interest Policy relating to the ramifications for not completing the survey within the designated parameters; this language is anticipated to be added in time for the roll-out to the entire population by May 2nd.

IV. Recommendations, Discussion/Information Item

A. Update from McGladrey LLP on FY2012 Audit

The following representatives from McGladrey LLP, provided an update on activities relating to the FY2012 Audit activities: Pat Kitchen, Partner; and Tim Heinrichs, Director. The Committee reviewed and discussed the information.

Mr. Kitchen stated that he is pleased to report very good progress on the audit activities; representatives from McGladrey continue to receive strong cooperation from System management. In terms of the System audit, there are elements of the financial statements that are audited by the Health System audit team, and elements that are audited by the County audit team. With respect to the items for which he and his colleagues have primary responsibility as the Health System audit team, those areas are substantially complete – including cash, inventory, capital assets, accrued vacation and third-party settlements; he stated that there are no significant issues to report.

With respect to the testing of patients accounts receivable, Mr. Kitchen stated that the testing is ongoing; they are hoping to conclude this soon, but to date, they have not encountered any issues or red flags/areas of concern with that testing.

The areas being audited by the County audit team include additional cash and investments, self-insurance liabilities, debt, pension liabilities, payroll, and various tax revenue. To date, there have been no communications from the County audit team with respect to any issues that would have a trickle-down effect, in terms of the Health System financial statements.

Mr. Kitchen stated that the County audit is progressing ahead of schedule; there is a fair amount of work yet to be done to complete the audit, in time for the County to file its Comprehensive Annual Financial Report (CAFR) by the May 31 deadline. With regard to the completion of the Health System financial statements, it was indicated that this should be completed sometime in May.

V. Action Items

A. Minutes of the Audit and Compliance Committee Meeting, January 23, 2013

Director Michael, seconded by Chairman Muñoz, moved to accept the minutes of the Audit and Compliance Committee Meeting of January 23, 2013. THE MOTION CARRIED UNANIMOUSLY.

B. Any items listed under Sections IV, V and VI

VI. Closed Session Items

A. **Report from System Corporate Compliance Officer
B. Report from System Director of Internal Audit
C. Discussion of Personnel Matters

Director Michael, seconded by Chairman Muñoz , moved to recess the regular session and convene into closed session, pursuant to the following exceptions to the Illinois Open Meetings Act: 5 ILCS 120/2(c)(**1**), regarding "the appointment, employment, compensation, discipline, performance, or dismissal of specific employees of the public body or legal counsel for the public body, including hearing testimony on a complaint lodged against an employee of the public body or against legal counsel for the public body to determine its validity," and 5 ILCS 120/2(c)(**28**), regarding "meetings between internal or external auditors and governmental audit committees, finance committees, and their equivalents, when the discussion involves internal control weaknesses, identification of potential fraud risk areas, known or suspected frauds, and fraud interviews conducted in accordance with generally accepted auditing standards of the United States of America." THE MOTION CARRIED UNANIMOUSLY.

Chairman Muñoz declared that the closed session was adjourned. The Committee reconvened into regular session.

VII. Adjourn

As the agenda was exhausted, Chairman Muñoz declared the meeting ADJOURNED.

Respectfully submitted,
Audit and Compliance Committee of the
Board of Directors of the
Cook County Health and Hospitals System

XXXXXXXXXXXXXXXXXXXXX
Luis Muñoz, MD, MPH, Chairman

Attest:

XXXXXXXXXXXXXXXXXXXXX
Deborah Santana, Secretary

[1] Follow-up: ER coding audit (expected to be completed in May) to be presented at next Audit and Compliance Committee Meeting (next regularly scheduled meeting is July 10, 2013). Page 2.

[2] Follow-up: assessment of the issue involving coding for Trauma Services to be provided. Page 3.

ATTACHMENT #1

Corporate Compliance Report

Cathy Bodnar, MS, RN, CHC
Chief Compliance & Privacy Officer

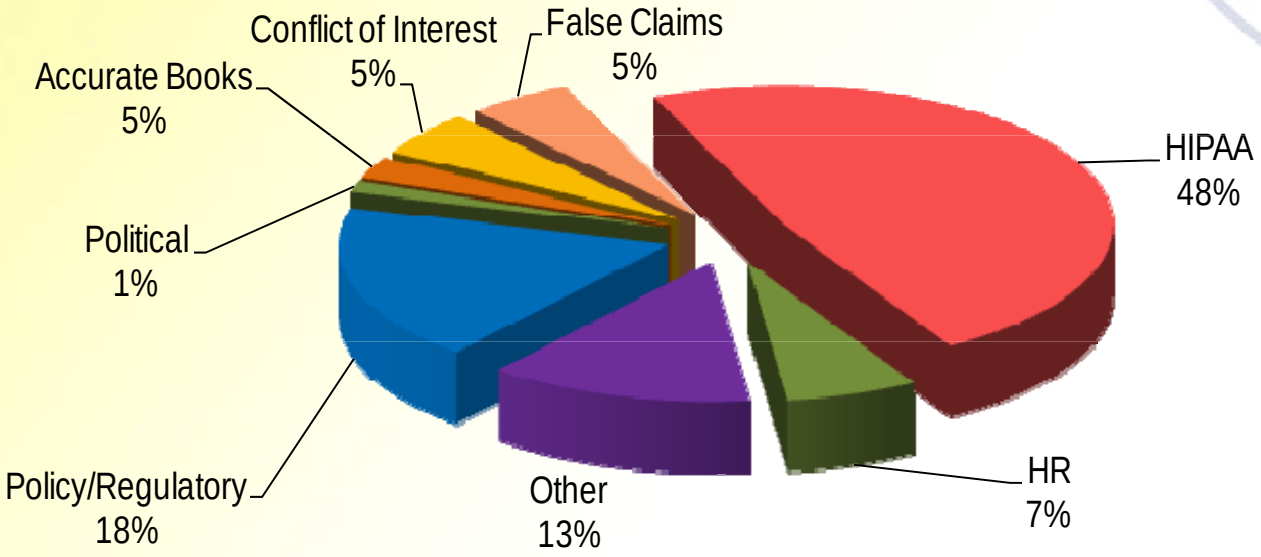
April 10, 2013

Meeting Objectives

- To file
  - Quarterly statistics on reactive compliance issues;
  - Annual sanction report for employees and vendors;
  - CY12 breach statistics.
- To provide Board education on the final HITECH Omnibus Rule.
- To report quarterly monitoring statistics for facility/technical coding and professional fee coding.
- To kick-off the Accounting of Disclosures Survey.

1st Quarter FY 2013 Activity

78 Reactive Corporate Compliance Issues Opened



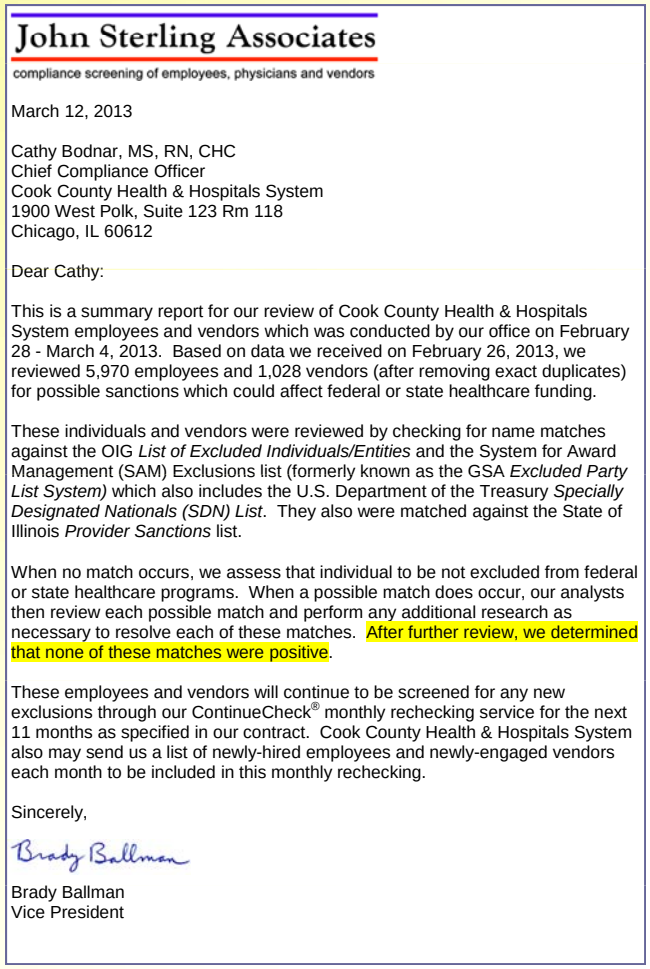
Actual Counts

Privacy (HIPAA)	37	Conflict of Interest	4	Theft	1
Policy/Regulatory	14	False Claims	4	Political Activity	1
Human Resources	5	Accurate Books	2	Other	10

New Category

3

Annual Sanction Screening Checks



John Sterling Associates

compliance screening of employees, physicians and vendors

March 12, 2013

Cathy Bodnar, MS, RN, CHC
Chief Compliance Officer
Cook County Health & Hospitals System
1900 West Polk, Suite 123 Rm 118
Chicago, IL 60612

Dear Cathy:

This is a summary report for our review of Cook County Health & Hospitals System employees and vendors which was conducted by our office on February 28 - March 4, 2013. Based on data we received on February 26, 2013, we reviewed 5,970 employees and 1,028 vendors (after removing exact duplicates) for possible sanctions which could affect federal or state healthcare funding.

These individuals and vendors were reviewed by checking for name matches against the OIG *List of Excluded Individuals/Entities* and the System for Award Management (SAM) Exclusions list (formerly known as the GSA *Excluded Party List System)* which also includes the U.S. Department of the Treasury *Specially Designated Nationals (SDN) List*. They also were matched against the State of Illinois *Provider Sanctions* list.

When no match occurs, we assess that individual to be not excluded from federal or state healthcare programs. When a possible match does occur, our analysts then review each possible match and perform any additional research as necessary to resolve each of these matches. After further review, we determined that none of these matches were positive.

These employees and vendors will continue to be screened for any new exclusions through our ContinueCheck® monthly rechecking service for the next 11 months as specified in our contract. Cook County Health & Hospitals System also may send us a list of newly-hired employees and newly-engaged vendors each month to be included in this monthly rechecking.

Sincerely,

Brady Ballman

Brady Ballman
Vice President

The checks are specialized searches to identify individuals or entities that have been sanctioned or debarred from participation in federally funded healthcare programs.

Sanction screening checks are a requirement for recipients of governmental funds.

CCHHS is prohibited from employing, engaging, contracting or agreeing with any individual or entity who is sanctioned or excluded from participation in a federal program.

← No Exclusions Identified for Employees or Vendors

COOK COUNTY HEALTH & HOSPITALS SYSTEM CCHHS

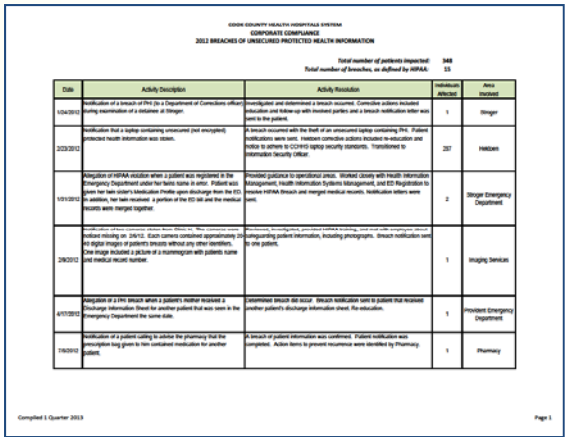
Breach Reporting 2012

Total Number of Individuals Affected by

Breaches of Unsecured Protected Health Information – 348

"Unsecured"

- Protected Health Information (PHI) has been rendered unusable, unreadable, or indecipherable to unauthorized individuals.
  - Electronic – must be encrypted following the requirements set forth within the HIPAA Security Rule.
  - Paper, film, or other hard copy media has been shredded or destroyed such that the PHI cannot be read or otherwise reconstructed.



COOK COUNTY HEALTH HOSPITALS SYSTEM

CORPORATE COMPLIANCE

2012 BREACHES OF UNSECURED PROTECTED HEALTH INFORMATION

Total number of patients impacted: 348

Total number of breaches, as defined by HIPAA: 15

Date	Activity Description	Activity Resolution	Individuals Affected	Area Involved
1/24/2012	Notification of a breach of PHI (by a Department of Corrections officer) during examination of a detainee at Stroger.	Investigated and determined a breach occurred. Corrective actions included education and follow-up with involved parties and a breach notification letter was sent to the patient.	1	Stroger
2/23/2012	Notification that a laptop containing unsecured (not encrypted) protected health information was stolen.	A breach occurred with the theft of an unsecured laptop containing PHI. Patient notifications were sent. Heldorn corrective actions included re-education and notice to adhere to CCHHS laptop security standards. Transitioned to Information Security Officer.	237	Heldorn
1/31/2012	Allegation of HIPAA violation when a patient was registered in the Emergency Department under her twins name in error. Patient was given her twin sister's Medication Profile upon discharge from the ED. In addition, her twin received a portion of the ED bill and the medical records were merged together.	Provided guidance to operational areas. Worked closely with Health Information Management, Health Information Systems Management, and ED Registration to resolve HIPAA Breach and merged medical records. Notification letters were sent.	2	Stroger Emergency Department
2/8/2012	Notification of two cameras stolen from Illinois Inc. The cameras were mailed missing on 2/6/12. Each camera contained approximately 20 no digital images of patient's breasts without any other identifiers. One image included a picture of a mammogram with patients name and medical record number.	Discovered, investigated, provided HIPAA training, and met with employee about safeguarding patient information, including pictographs. Breach notification sent to one patient.	1	Imaging Services
4/17/2012	Allegation of a PHI breach when a patient's mother received a Discharge Information Sheet for another patient that was seen in the Emergency Department the same date.	Determined breach did occur. Breach notification sent to patient that received another patient's discharge information sheet. Re-education.	1	Provident Emergency Department
7/6/2012	Notification of a patient calling to advise the pharmacy that the prescription bag given to him contained medication for another patient.	A breach of patient information was confirmed. Patient notification was completed. Action items to prevent recurrence were identified by Pharmacy.	1	Pharmacy

Compiled 1 Quarter 2013 Page 1

Questions?

HIPAA Omnibus Rule

- Published on January 25, 2013; effective on March 26, 2013.
- Compliance is mandated by September 23, 2013.
- New restrictions and obligations include:
  - Modifications to, and redistribution of, the Notice of Privacy Practices;
  - Expands the definition of a Business Associate – BAs now become directly liable for compliance with HIPAA;
  - Increases an individuals' rights to receive electronic copies of their health information;
  - Restricts disclosures to health plans concerning treatment for which the individual has paid out of pocket in full; and
  - Prohibits the sale of protected health information without individual authorization.

Putting Things in Perspective

March 12, 2013 roundtable with DHHS OCR Director Leon Rodriguez,

- Compliance is mandatory.
- Breaches will continue to happen…and OCR knows it.
- The key to avoiding costly fines and penalties is
  - to have the ability to show OCR what was in place to prevent the breach in the first place,
  - to investigate and mitigate the effects of the breach when it occurred, and
  - to review the HIPAA compliance program generally as a result of the breach to prevent it from recurring.

What's the Key to Compliance?

Document Everything – Documentation establishes intent.

- "Everything" includes the policies and procedures that were in place at the time of the breach that were designed to prevent the breach from occurring in the first place. Documentation includes,
  - Verification that workforce members received training on the policies and procedures;
  - Evidence of the report and subsequent investigation of the breach;
  - Action taken to mitigate the breach and notifications made to the individuals affected by the breach; and, if applicable,
  - Re-evaluation and modification to policies and procedures made as a result of the breach and its investigation.

Questions?

Professional Coding Reviews

Externally Performed by McKesson

- Retrospective reviews are performed quarterly.
- All staff performing CCHHS coding are reviewed.
- Thirty (30) patient records are selected.
- The records reviewed reflect a range of services.
- Performance is scored utilizing the following table:

Accuracy Levels	Scoring		Remediation
	CPT/Modifiers	ICD-9-CM	
Minimum Standard	95%	95%	
Green	95 - 100%	95 - 100%	Feedback on errors
Yellow	90 - 94.99%	90 - 94.99%	Feedback; if no improvement in 3 quarters - corrective action plan.
Orange	85 - 89.99%	85 - 89.99%	Corrective action plan with customized training to address weaknesses. Corrective actions become more focused with increasing levels of monitoring until improvement.
Red	Below 85%	Below 85%	Monitoring all coding. Corrective action plan with customized training to address weaknesses. If no improvement, removed from production.

Professional Coding Statistics

Quarter 4 - October - December 2012			
Coder	CPT/Modifiers	ICD-9-CM	Action
1	100.0%	95.8%	NA
2	90.0%	100.0%	Feedback; ongoing monitoring
3	90.0%	100.0%	Feedback; ongoing monitoring
4	86.7%	96.7%	Monitor with corrective action plan.
5	60.0%	95.0%	Remediation; 100% monitoring until compliant.
6	90.0%	96.0%	Feedback; ongoing monitoring
9	96.4%	98.2%	NA
12	80.0%	89.0%	Remediation; 100% monitoring until compliant.
14	43.3%	50.8%	Coder removed from production
15	86.7%	99.2%	Monitor with corrective action plan.
16	77.4%	90.3%	Remediation; 100% monitoring until compliant.
19	82.8%	96.9%	Remediation; 100% monitoring until compliant.
26	96.8%	98.4%	NA
27	96.7%	100.0%	NA
28	95.5%	100.0%	NA
29	86.7%	88.3%	Monitor with corrective action plan.
30	90.0%	92.5%	Feedback; ongoing monitoring
31	86.7%	85.0%	Monitor with corrective action plan.
32	84.1%	100.0%	Remediation; 100% monitoring until compliant.
33	95.6%	99.3%	NA
34	95.1%	95.1%	NA
35	90.3%	88.7%	Monitor with corrective action plan.
36	86.7%	85.8%	Monitor with corrective action plan.
37	91.4%	92.2%	Feedback; ongoing monitoring
38	96.6%	100.0%	NA
39	93.8%	92.2%	Feedback; ongoing monitoring
40	94.9%	95.5%	Feedback; ongoing monitoring
41	100.0%	100.0%	NA
42	73.0%	90.0%	Remediation; 100% monitoring until compliant.
43	70.0%	82.8%	Remediation; 100% monitoring until compliant.
44	90.9%	98.3%	Feedback; ongoing monitoring
45	66.0%	93.0%	Remediation; 100% monitoring until compliant.

Questions?

CCHHS Coding Reviews

Externally Performed Review of CCHHS Coding Staff

- A random sample of 1,203 inpatient records.
- The sample assessed 5% of John H. Stroger, Jr. Hospital discharge records from FY 2012.
- CCHHS overall accuracy rate was **94.1%**.
- Industry benchmark for coding accuracy is 95%.

Quality Improvement Activity

- External review results used to educate coders to improve coding accuracy.

Current State

The mission of the Health Information Management Coding Office is to centralize and standardize coding throughout CCHHS.

Position	Budgeted	Filled	Vacant
Sr. Coder (Credentialed)	23	12	11
Jr. Coder	2	2	0
Total	25	14	11*

* External coding vendors supplement current activity with real-time flexible staffing.

Productivity Standards

CCHHS Coding Standard	
Record Type	Record Per Hour
Inpatient	3
Observation	4
Same Day Surgery	7
ED Records	8
Outpatient Clinic/ Diagnostics	25

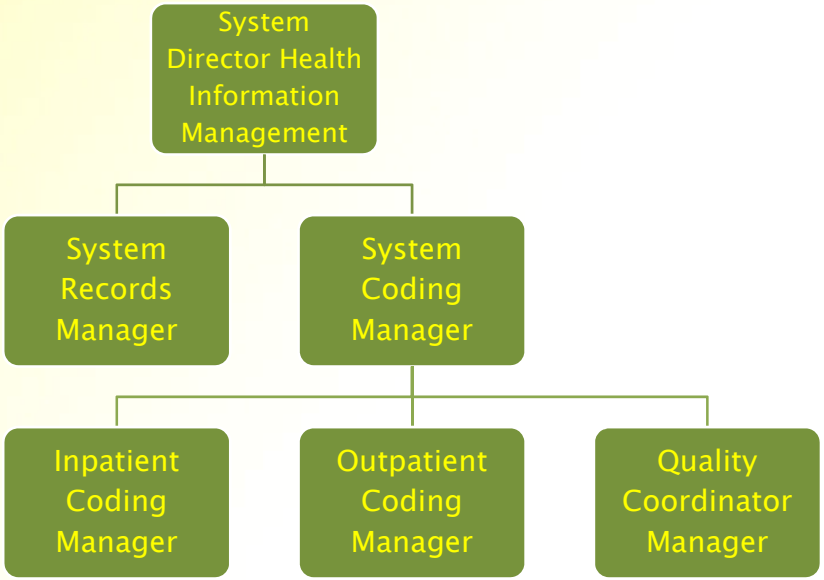
Action Plan for Coders Not Achieving Standards

- < 85% case-by-case review
- 30 – 60 – 90 day counseling corrective action plan
- Over 90 days without improvement, progressive disciplinary action plan.

Future State

Goals

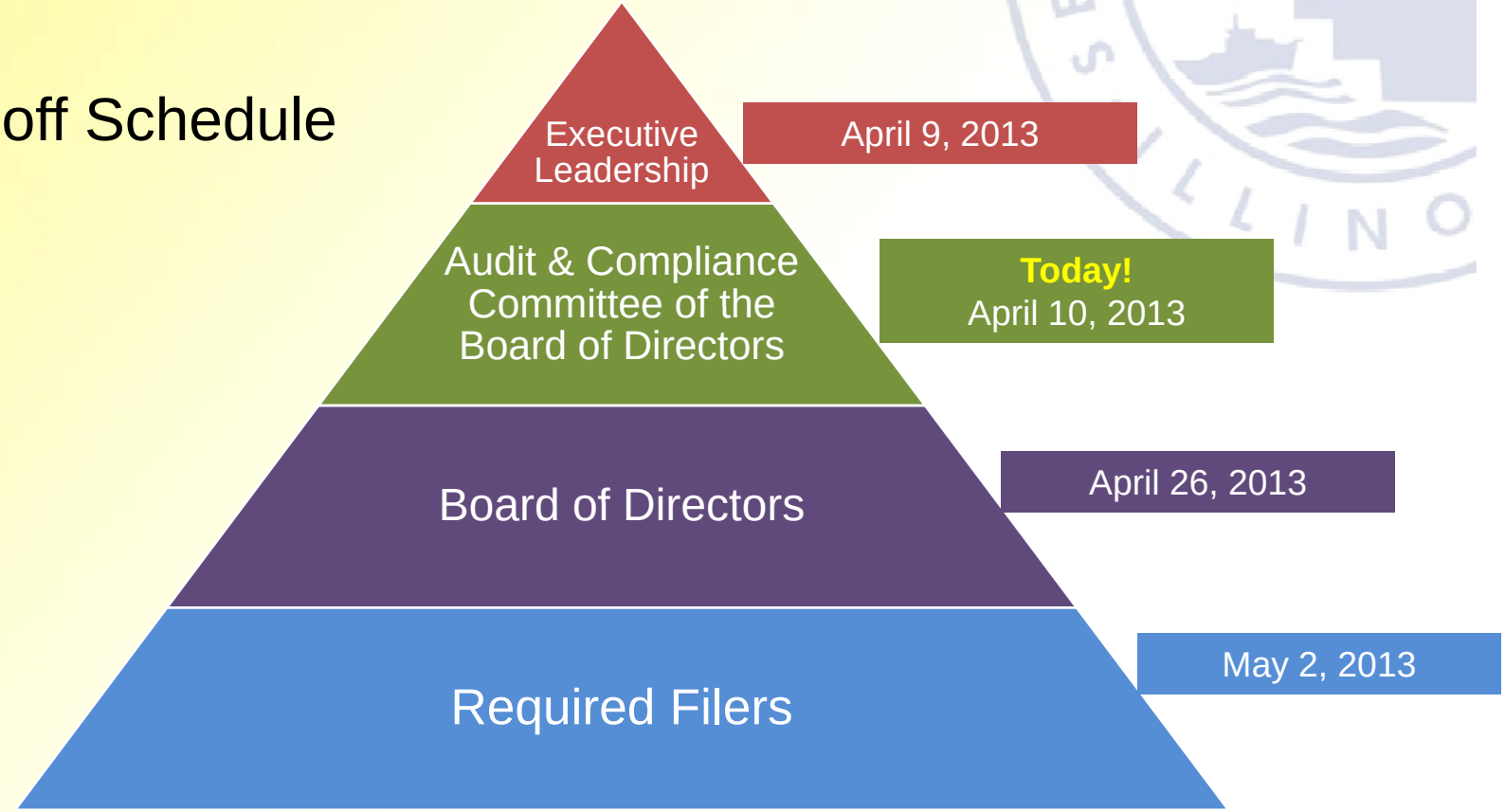
- Comply with ICD-10-CM and ICD-10-PCS by October 1, 2014 by,
  - Engaging an external project manager;
  - Initiating system-wide education to providers (documentation) and coders (anatomy & physiology); and
  - Procure necessary software.
- Centralize coders to one location.



Questions?

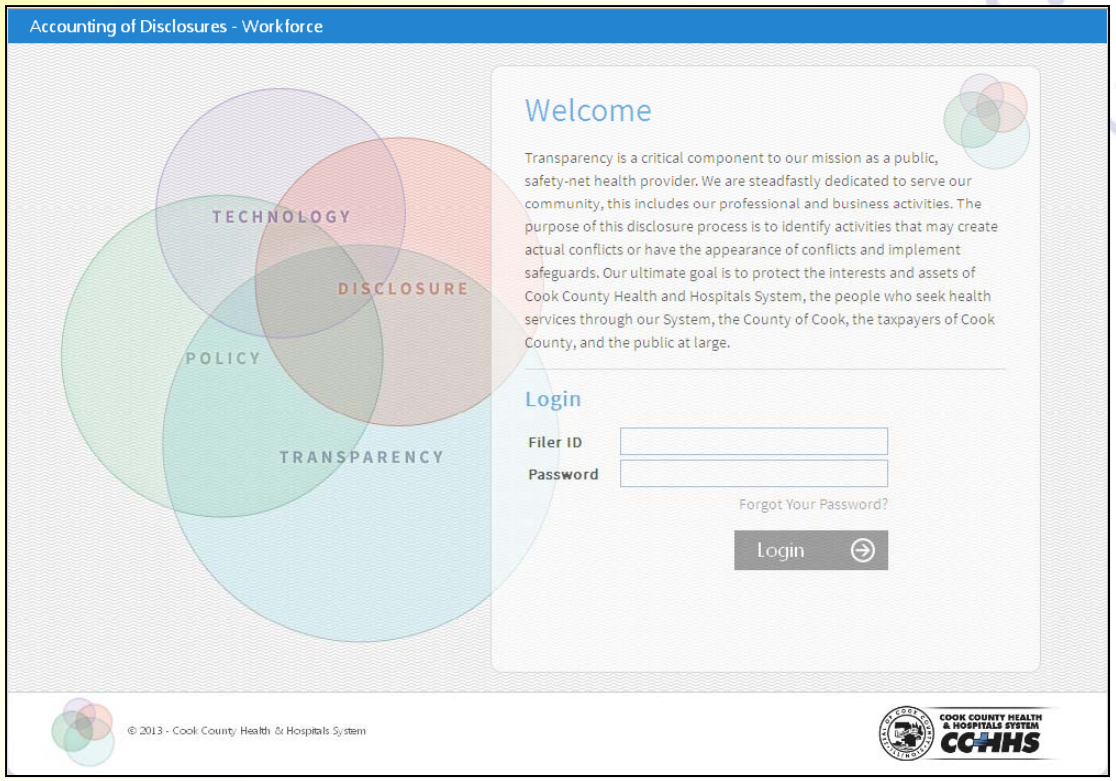
Accounting of Disclosures Survey

Kick-off Schedule

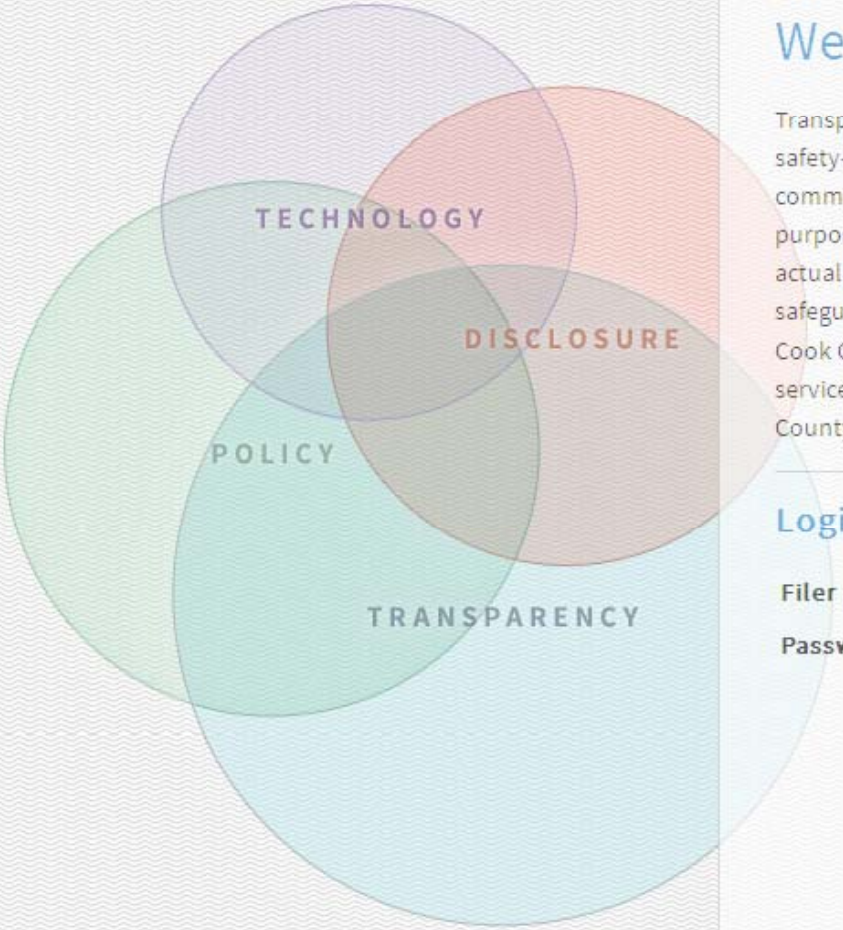


FY 13 Work Plan

Deploy system-wide conflict of interest data collection tool for annual attestation and reporting changes throughout the year.



Accounting of Disclosures - Workforce



Welcome

Transparency is a critical component to our mission as a public, safety-net health provider. We are steadfastly dedicated to serve our community, this includes our professional and business activities. The purpose of this disclosure process is to identify activities that may create actual conflicts or have the appearance of conflicts and implement safeguards. Our ultimate goal is to protect the interests and assets of Cook County Health and Hospitals System, the people who seek health services through our System, the County of Cook, the taxpayers of Cook County, and the public at large.

Login

Filer ID

Password

Forgot Your Password?

Login

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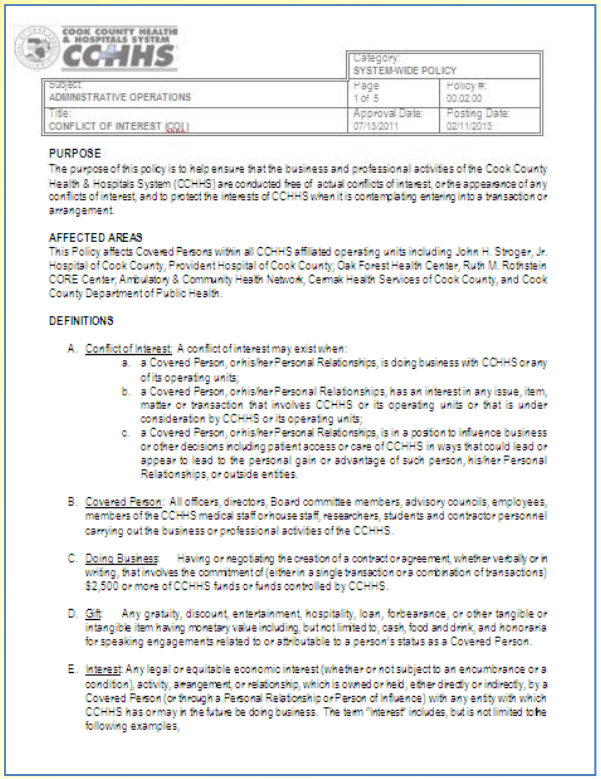
Conflict of Interest Policy



COOK COUNTY HEALTH & HOSPITALS SYSTEM
CCHHS

Subject: ADMINISTRATIVE OPERATIONS	Page 1 of 5	Category: SYSTEM-WIDE POLICY Policy #: 00.02.00
Title: CONFLICT OF INTEREST (COI)	Approval Date: 07/13/2011	Posting Date: 02/11/2013

PURPOSE

The purpose of this policy is to help ensure that the business and professional activities of the Cook County Health & Hospitals System (CCHHS) are conducted free of actual conflicts of interest, or the appearance of any conflicts of interest, and to protect the interests of CCHHS when it is contemplating entering into a transaction or arrangement.

AFFECTED AREAS

This Policy affects Covered Persons within all CCHHS affiliated operating units including John H. Stroger, Jr. Hospital of Cook County, Provident Hospital of Cook County, Oak Forest Health Center, Ruth M. Rothstein CORE Center, Ambulatory & Community Health Network, Cermak Health Services of Cook County, and Cook County Department of Public Health.

DEFINITIONS

A. Conflict of Interest: A conflict of interest may exist when:
   a. a Covered Person, or his/her Personal Relationships, is doing business with CCHHS or any of its operating units;
   b. a Covered Person, or his/her Personal Relationships, has an interest in any issue, item, matter or transaction that involves CCHHS or its operating units or that is under consideration by CCHHS or its operating units;
   c. a Covered Person, or his/her Personal Relationships, is in a position to influence business or other decisions including patient access or care of CCHHS in ways that could lead or appear to lead to the personal gain or advantage of such person, his/her Personal Relationships, or outside entities.

B. Covered Person: All officers, directors, Board committee members, advisory councils, employees, members of the CCHHS medical staff or house staff, researchers, students and contractor personnel carrying out the business or professional activities of the CCHHS.

C. Doing Business: Having or negotiating the creation of a contract or agreement, whether verbally or in writing, that involves the commitment of (either in a single transaction or a combination of transactions) $2,500 or more of CCHHS funds or funds controlled by CCHHS.

D. Gift: Any gratuity, discount, entertainment, hospitality, loan, forbearance, or other tangible or intangible item having monetary value including, but not limited to, cash, food and drink, and honoraria for speaking engagements related to or attributable to a person's status as a Covered Person.

E. Interest: Any legal or equitable economic interest (whether or not subject to an encumbrance or a condition), activity, arrangement, or relationship, which is owned or held, either directly or indirectly, by a Covered Person (or through a Personal Relationship or Person of Influence) with any entity with which CCHHS has or may in the future be doing business. The term "interest" includes, but is not limited to the following examples;

Adding language to address the ramifications of not completing the survey within the designated parameters.

Questions?

Closed Session Discussion

COOK COUNTY HEALTH HOSPITALS SYSTEM
CORPORATE COMPLIANCE
2012 BREACHES OF UNSECURED PROTECTED HEALTH INFORMATION

Total number of patients impacted: **348**
Total number of breaches, as defined by HIPAA: **15**

Date	Activity Description	Activity Resolution	Individuals Affected	Area Involved
1/24/2012	Notification of a breach of PHI (to a Department of Corrections officer) during examination of a detainee at Stroger.	Investigated and determined a breach occurred. Corrective actions included education and follow-up with involved parties and a breach notification letter was sent to the patient.	1	Stroger
2/23/2012	Notification that a laptop containing unsecured (not encrypted) protected health information was stolen.	A breach occurred with the theft of an unsecured laptop containing PHI. Patient notifications were sent. Hektoen corrective actions included re-education and notice to adhere to CCHHS laptop security standards. Transitioned to Information Security Officer.	257	Hektoen
1/31/2012	Allegation of HIPAA violation when a patient was registered in the Emergency Department under her twins name in error. Patient was given her twin sister's Medication Profile upon discharge from the ED. In addition, her twin received a portion of the ED bill and the medical records were merged together.	Provided guidance to operational areas. Worked closely with Health Information Management, Health Information Systems, and ED Registration to resolve HIPAA Breach and merged medical records. Notification letters were sent.	2	Stroger Emergency Department
2/9/2012	Notification of two cameras stolen from Clinic H. The cameras were noticed missing on 2/6/12. Each camera contained approximately 20-40 digital images of patient's breasts without any other identifiers. One image included a picture of a mammogram with patients name and medical record number.	Reviewed, investigated, provided HIPAA training, and met with employee about safeguarding patient information, including photographs. Breach notification sent to one patient.	1	Imaging Services
4/17/2012	Allegation of a PHI breach when a patient's mother received a Discharge Information Sheet for another patient that was seen in the Emergency Department the same date.	Determined breach did occur. Breach notification sent to patient that received another patient's discharge information sheet. Re-education.	1	Provident Emergency Department
7/5/2012	Notification of a patient calling to advise the pharmacy that the prescription bag given to him contained medication for another patient.	A breach of patient information was confirmed. Patient notification was completed. Action items to prevent recurrence were identified by Pharmacy.	1	Pharmacy
7/9/2012	Allegation of PHI breach when a physician e-mailed the American Medical Association, Patient Safety Consortium, screen shots containing protected health information on two patients. E-mail was sent from an AOL account to an AMA e-mail address, both addresses are outside CCHHS firewall.	Security breach validated. Patients notified. Employee remediation pursuant to the recommendations of the Hearing Officer.	2	Medical Staff

COOK COUNTY HEALTH HOSPITALS SYSTEM
CORPORATE COMPLIANCE
2012 BREACHES OF UNSECURED PROTECTED HEALTH INFORMATION

Date	Activity Description	Activity Resolution	Individuals Affected	Area Involved
7/16/2012	Notification of a story on a local television station about the Stroger Hospital's Trauma Unit.	Re-education to operational area. Patient breach notification letters were sent. Policy, authorization, and guidance will be routed through approval process.	3	Public Relations
8/7/2012	Notification that a vendor, Discovery Copy Services, faxed a medical record to the wrong fax number/recipient.	The erroneous fax was destroyed and the correct recipient was sent the materials. A breach notification letter was sent to the patient. The supervisor discussed the incident with the employee and a written record was put in their personnel file.	1	Discover Copy Service
8/30/2012	Notification of a patient complaint where the patient requested copies of their medical record and received, in addition to their own, medical records, records of another patient.	The medical records that did not belong to the patient requesting their own record were returned to CCHHS. An internal investigation determined it to be a clerical error. A letter was sent notifying the patient of the breach.	1	HIM
11/19/2012	Allegation of a pharmacy prescription given to the wrong patient.	Breach of patient information was confirmed. A breach notification letter was sent to the patient. Corrective action plan put in place with Pharmacy.	1	Pharmacy
11/7/2012	Notification of PGY1 inadvertently giving PHI without permission.	A (verbal) breach of PHI did occur. A breach notification letter was sent to the patient. The involved staff was assigned and completed additional computer-based training courses on privacy and confidentiality.	1	Medical Staff
11/29/2012	Notified of an article in the Chicago Tribune that contained an image (photograph) of patients.	Confirmed that authorization was not obtained and a breach occurred. A breach notification letter was sent to all patients that were seen in the ED during the time the reporter was there. Updated policy, procedures and forms - authorization for patient and confidentiality for members of the media.	74	Public Relations
12/17/2012	Notification of use of "HIV POSITIVE" sticker on a patient chart.	Investigation validated that a breach occurred related to HIV diagnosis. A breach notification letter was sent to the patient. Corrective actions, including retraining in process.	1	Nursing
10/29/2012	Notification that two patients (same last name) received each other medications during the discharge process. One of the medications was a controlled substance.	Breach of patient information was confirmed. A breach notification letter was sent to the patient. Corrective action plan put in place with Pharmacy.	1	Nursing / Pharmacy

Total number of patients impacted: **348**
Total number of breaches, as defined by HIPAA: **15**

McKESSON
Empowering Healthcare

Professional Coding Statistics
Quarter 3 and 4 2012

Quarter 3 - July - October 2012				Quarter 4 - October - December 2012		
Coder	CPT/Modifiers	ICD-9-CM	Action	CPT/Modifiers	ICD-9-CM	Action
1	97.70%	93.10%	Feedback; ongoing monitoring	100.0%	95.8%	NA
2	83.30%	99.20%	Remediation; 100% monitoring until compliant.	90.0%	100.0%	Feedback; ongoing monitoring
3	93.00%	95.00%	Feedback; ongoing monitoring	90.0%	100.0%	Feedback; ongoing monitoring
4	93.00%	96.00%	Feedback; ongoing monitoring	86.7%	96.7%	Monitor with corrective action plan.
5	93.50%	99.20%	Feedback; ongoing monitoring	60.0%	95.0%	Remediation; 100% monitoring until compliant.
6	90.00%	93.30%	Feedback; ongoing monitoring	90.0%	96.0%	Feedback; ongoing monitoring
7	90.40%	97.30%	Feedback; ongoing monitoring	Did Not Code		
8	100.00%	98.00%	Feedback; ongoing monitoring	Did Not Code		
9	93.00%	99.60%	Feedback; ongoing monitoring	96.4%	98.2%	NA
10	100.00%	100.00%	NA	Did Not Code		
11	93.30%	99.20%	Feedback; ongoing monitoring	Did Not Code		
12	86.70%	86.70%	Feedback; monitor during 4th quarter	80.0%	89.0%	Remediation; 100% monitoring until compliant.
13	43.30%	88.30%	Coder removed from production	Did Not Code		
14	93.30%	100.00%	Feedback; ongoing monitoring	43.3%	50.8%	Coder removed from production
15	90.00%	95.00%	Feedback; ongoing monitoring	86.7%	99.2%	Monitor with corrective action plan.
16	90.00%	100.00%	Feedback; ongoing monitoring	77.4%	90.3%	Remediation; 100% monitoring until compliant.
17	73.00%	85.00%	Remediation; 100% monitoring until compliant.	Did Not Code		
18	86.70%	96.70%	Feedback; monitor during 4th quarter	Did Not Code		
19	93.30%	100.00%	Feedback; ongoing monitoring	82.8%	96.9%	Remediation; 100% monitoring until compliant.
20	96.70%	96.70%	Feedback; ongoing monitoring	Did Not Code		
21	100.00%	96.00%	Feedback; ongoing monitoring	Did Not Code		
22	50.00%	78.70%	Coder removed from production	Did Not Code		
23	64.00%	91.00%	Coder removed from production	Did Not Code		
24	50.00%	90.00%	Coder removed from production	Did Not Code		
25	60.00%	86.00%	Coder removed from production	Did Not Code		
26	96.80%	98.40%	Feedback; ongoing monitoring	96.8%	98.4%	NA
27	96.70%	100.00%	Feedback; ongoing monitoring	96.7%	100.0%	NA
28	95.50%	100.00%	Feedback; ongoing monitoring	95.5%	100.0%	NA
29	Did Not Code			86.7%	88.3%	Monitor with corrective action plan.
30	Did Not Code			90.0%	92.5%	Feedback; ongoing monitoring
31	Did Not Code			86.7%	85.0%	Monitor with corrective action plan.
32	Did Not Code			84.1%	100.0%	Remediation; 100% monitoring until compliant.
33	Did Not Code			95.6%	99.3%	NA
34	Did Not Code			95.1%	95.1%	NA
35	Did Not Code			90.3%	88.7%	Monitor with corrective action plan.
36	Did Not Code			86.7%	85.8%	Monitor with corrective action plan.
37	Did Not Code			91.4%	92.2%	Feedback; ongoing monitoring
38	Did Not Code			96.6%	100.0%	NA
39	Did Not Code			93.8%	92.2%	Feedback; ongoing monitoring
40	Did Not Code			94.9%	95.5%	Feedback; ongoing monitoring
41	Did Not Code			100.0%	100.0%	NA
42	Did Not Code			73.0%	90.0%	Remediation; 100% monitoring until compliant.
43	Did Not Code			70.0%	82.8%	Remediation; 100% monitoring until compliant.
44	Did Not Code			90.9%	98.3%	Feedback; ongoing monitoring
45	Did Not Code			66.0%	93.0%	Remediation; 100% monitoring until compliant.
46	Did Not Code			100.0%	96.0%	NA
47	Did Not Code			91.4%	92.9%	Feedback; ongoing monitoring
48	Did Not Code			93.6%	97.9%	Feedback; ongoing monitoring
49	Did Not Code			75.0%	90.0%	Remediation; 100% monitoring until compliant.
50	Did Not Code			58.1%	98.4%	Remediation; 100% monitoring until compliant.
51	Did Not Code			90.0%	96.7%	Feedback; ongoing monitoring
52	Did Not Code			68.8%	79.7%	Coder removed from production
53	Did Not Code			73.3%	85.8%	Coder removed from production
54	Did Not Code			73.0%	90.0%	Remediation; 100% monitoring until compliant.